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Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective 01/01/2014

Line(s) of Business	**Line(s) of Insurance**
Individual Health Maintenance Organization **Affordable Care Act Benchmark Requirements**	**Individual HMO Policies** **(Includes Point of Service Products)** **For Insurance Exchange use only**

Illinois Insurance Code Link	Illinois Compiled Statutes Online		
Illinois Administrative Code Link	Administrative Regulations Online		
Product Coding Matrix	**Product Coding Matrix**		
REVIEW REQUIREMENTS	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
		NOTE: These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Department of Insurance.	
FORM FILING REQUIREMENTS	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
Filing of Marketing and Advertising Materials	50 IL Admin. Code 5421.100 c)	All brochures, media scripts, marketing and advertising material must be filed with the Division of Insurance prior to use.	
Review Requirements Checklist	Go to Review Requirements Checklists on DOI web site. See next column	Each filing must include a completed Review Requirements Checklist that must contain a completed “Location of Standard in Filing” column for each required element of the filing. Please indicate the proper page # and form # for each entry.	
Cover Letter and Letter of Submission	50 IL Adm. Code 1405.20 (e) 50 IL Adm. Code 2001.30 (a) (3) 50 IL Adm. Code 916.40 (b)	Cover Letters must generally describe the intent of the rate filing and whether the filing is a new rate, rate revision or justification of an existing rate. It is necessary to provide a listing of the policy form filing company tracking number(s) and company form number(s) to show the association between the rate being filed and those forms affected by the rate change. ** The Filing Description field in the General Information Tab in SERFF may be used in place of a cover letter.	
GENERAL REQUIREMENTS FOR ALL FILINGS	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
Entire Contract	50 IL Adm. Code 5421.110 d)	The group contract and evidence of coverage, including the application and any amendments and riders, constitutes the entire contract between the parties.	

Timely Payment of Health Care Services	215 ILCS 5/368a	Periodic payments must be made within 60 days of an enrollee's selection of a provider, or effective date of selection, whichever is later. In case of retrospective enrollment only 30 days after notice by the employer to the insurer. Subsequent payments must be in monthly periodic cycle. Penalty payment of 9% per year. Payments other than periodic must be made within 30 days after receipt of due proof of loss. Same penalty provisions.	
Grace Period	50 IL Adm. Code 5421.110 m)	A group contract must provide for a grace period of no less than 10 days.	
Grace period for advance premium tax credit recipients	45CFR 155.430, and 156.270	A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, the QHP issuer must terminate the enrollee's coverage on the effective date described in 45 CFR 155.430(d)(4), provided that the QHP issuer meets the notice requirement specified in paragraph (b) of that section. During the grace period, the QHP issuer must: • Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; • Notify HHS of such non-payment; and, • Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.	Grace period for advance premium tax credit recipients
Eligibility Requirements	50 IL Adm. Code 5421.110 e)	The group contract and evidence of coverage must contain eligibility requirements that explain the conditions that must be met to enroll in the plan, the limiting age for enrollees and eligible dependents, including the effects of Medicare eligibility, and a clear statement regarding newborn coverage.	
Cancellation	50 IL Adm. Code 5421.110 k) 50 IL Adm. Code 5421.111 a)	No HMO may cancel a group contract or evidence of coverage except for one or more of the following reasons: • Failure to pay the premium; • Fraud or material misrepresentation; • Material violation of the terms of the contract or evidence of coverage; • Failure to establish a satisfactory patient-physician relationship; • Failure to meet or continue to meet eligibility requirements under the Basic Outpatient Preventive and Primary Care Services for Children Program offered by 50 IL Adm. Code 5421.131; or, • Such other good cause as appears in the contract.	

Extended age dependent continuation	215 ILCS 5/356z.12 215 ILCS 125/5-3(a)	A policy that includes dependent coverage must allow unmarried dependents under the age of 26 to apply for coverage. Additionally, polices must allow military veteran dependents under the age of 30 to apply for coverage if the veteran is an Illinois resident, not married; has served in the active or a reserve components of the U.S. Armed Forces (including the National Guard) and has received a release or discharge other than dishonorable.	
Dependent students; medical leave of absence continuation	215 ILCS 5/356z.11 215 ILCS 125/5-3(a)	A policy must continue to provide coverage for a dependent college student who has taken a medical leave of absence or reduced hours to part-time status due to a catastrophic illness or injury. Continuation is subject to all of the policy's terms and conditions applicable to that form of insurance and shall terminate 12 months after the notice of the illness or injury or until coverage would have otherwise lapsed. This coverage mirrors the requirements of H.R. 285, known as Michelle's Law, signed by the President on October 9, 2008.	
Newborn Coverage	215 ILCS 125/4-8	The contract or evidence of coverage must state newborns are covered from the moment of birth. If additional premium is required the insurer may require notification within 31 days in order to have coverage continue.	
Pending & Adopted Children	215 ILCS 125/4-9	No contract that covers the insured's immediate family or children may exclude or limit coverage of an adopted child or a child not residing with the insured (foster child). A child residing with an enrollee pursuant to an interim court order of adoption is considered an adopted child.	
Reinstatement	50 IL Adm. Code 5421.110 l)	The group contract and evidence of coverage must contain the conditions of the enrollee's right to reinstatement.	
Disabled Dependents	215 ILCS 125/4-9.1 50 IL Adm. Code 5421.110 u)	Provides continuation for handicapped dependent that has attained the limiting age of the contract.	
Deductibles and Copayments	50 IL Adm. Code 5421.110 i)	An HMO may require copayments, but not to exceed 50% of the usual and customary fee of the service. Maximum co-pays per calendar year are $6.250 per enrollee and $12,500 per family.	
Out of Area Benefits and Services	50 IL Adm. Code 5421.110 h)	The group contract and evidence of coverage must contain a specific description of the benefits and services that are available out of the HMO's service area.	
Benefits and Services Within the Service Area	50 IL Adm. Code 5421.110 f)	The group contract and evidence of coverage must contain a specific description of the benefits and services that are available in the HMO's service area.	
Grievance Procedure	50 IL Adm. 5421.110 x)	The group contract and evidence of coverage must provide a full description of the HMO's grievance procedure.	

Limitations and Exclusions	215 ILCS 125/4-14(3) 50 IL Adm. Code 5421.110 b)	There must be a detailed statement in the group contract and evidence of coverage that describes the limitations and exclusions expressed with the same prominence as the description of the benefits.	
Notice of Address of Division of Insurance	50 IL Adm. Code 5421.110 n)	No evidence of coverage may be issued without notice of the complaint department of the HMO and the address of the Managed Care Unit of the Division of Insurance.	
REQUIREMENTS RELATING TO POLICY FORM REVIEW	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
Basic Health Care Services	50 IL Adm. Code 5421.130	This section contains the minimum standards that must be met for basic health care services provided those services are determined to be medically necessary by the enrollee's primary care physician (PCP). Some of these services are outlined in more detail in this section of the checklist.	
Description of in-plan and out-of-plan Benefits	50 IL Adm. Code 5421.110 f) h)	The group contract and evidence of coverage must contain a specific description of benefits and services available both in-plan and out-of plan.	
Prescription Drugs, Cancer Treatment: Off-Label Use	215 ILCS 125/4-6.3	No HMO that provides prescription drug coverage for certain types of cancer may exclude coverage of any drug on the basis that the drug has not been FDA approved for that particular type of cancer if documentation is provided in certain medical reference compendia as to the efficacy of that drug for the form of cancer in question, or if the drug has been recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals here or in Great Britain.	
Outpatient Rehabilitative Therapy	50 IL Adm. Code 5421.130 j)	Coverage must include, but is not limited to, speech, physical and occupational therapy for up to 60 treatments per year.	
Health Care External Review Act	215 ILCS 5/155.36 215 ILCS 180/ 215 ILCS 180/75 215 ILCS 134/45	The Act provides uniform standards for the establishment and maintenance of external review procedures. Please note the disclosure provisions in section 75.	
Health Care External Review Act Time Frame Requirements	215 ILCS 180/35 215 ILCS 180/40 215 ILCS 180/42 (PDF of chart goes here)	Please note the statutory references for the time lines for external review as well as a chart to aid for compliance purposes.	
Health Care External Review Carrier Obligations for Filing Notices and Forms	215 ILCS 180/20 50 IL Adm. Code 5430.40	Health carriers must file for approval sample copies of: • Notices and forms required to file for a right to external review • Descriptions for both standard and expedited external review procedures • Statements informing the insured and any authorized representative that a standard or expedited external review request deemed ineligible by the plan may be appealed to the Department of Insurance by filing a complaint • Notification (until July 1, 2013) that if an external	

		independent review upholds an adverse determination the insured has a right to appeal that decision to the Department of Insurance	
REQUIREMENTS SPECIFIC TO HIPPA	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
Pre-Existing Conditions	ACA	Pre-existing condition exclusions are no longer permitted.	
Guaranteed Renewability	215 ILCS 97/30(A)(B)	Insurers in the small group or large group market must renew or continue in force a group's coverage at the option of the plan sponsor. Such guaranteed renewability is not applicable in cases of nonpayment of premium, fraud or misrepresentation, and violation of minimum participation requirements. For insurers ceasing to market to small or large group market or both, network plans may nonrenew coverage if there are no enrollees of the group who live, reside or work in the service area. Coverage through a bona fide association may be nonrenewed if the employer ceases to be a member of the association.	
Uniform Termination of Coverage Notification Requirements	215 ILCS 97/50 (C)	Insurers must comply with the uniform notification requirements for discontinuing a particular type of coverage and discontinuing all coverage in the state. Notification requirements must appear in certificate.	
Notice Requirement	215 ILCS 97/60	An insurer electing to uniformly modify, terminate or discontinue coverage in accordance with Section 30 or 50 of Act 97 (HIPAA) must provide 90 days advance notice to the Division by certified mail.	
MANAGED CARE REFORM AND PATIENT RIGHTS ACT PROVISIONS	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
Transition of Services	215 ILCS 134/25 50 IL Adm. Code 5420.60	A health care plan must provide for continuity of care for an ongoing course of treatment for its enrollees in circumstances in which the enrollee's PCP leaves the network as described. Treatment is available for 90 days from the date of the notice of the physician's termination or if the enrollee has entered the third trimester of a pregnancy.	
Emergency Services Prior to Stabilization	215 ILCS 134/65 50 IL Adm. Code 5420.110	A health care plan that provides, or is required to provide, coverage for emergency services may not make payments contingent upon whether the provider is in or out-of plan, or whether prior authorization is obtained.	
Post-Stabilization Medical Services	215 ILCS 134/70 50 IL Adm. Code 5420.120	The health care plan will be responsible for providing post-stabilization medical services if authorization is received from the health care plan, or one of its delegated providers, or after 2 documented good faith efforts by the treating health care provider as described.	

Standing Referral to Specialist	215 ILCS 134/40(b)	A health care plan shall establish a procedure by which an enrollee who requires the treatment of a specialist physician or other health care provider may obtain a standing referral to that individual. Such a referral may be effective for up to one year and may be renewed and re-renewed.	
Utilization of Health Care Facilities	215 ILCS 134/43	A health care plan must provide its enrollees with a description of their rights and responsibilities for obtaining referrals and for making appropriate use of health care facilities when their PCP is not available.	
Administrative Appeals: Complaint Handling Procedures	215 ILCS 134/50 215 ILCS 134/55 215 ILCS 125/4-6 50 IL Adm. Code 5420.90	An HMO is required to establish a procedure to handle complaints regarding administrative issues and procedures, but nothing in these requirements prevents an enrollee from filing a complaint with the Division. An HMO is required to respond to a complaint received from the Division of Insurance within 21 days of such notification.	
Appeals and Grievances Relating to Health Care Services	215 ILCS 134/45(a)(b)(c), (d)	An HMO must establish procedures for both expedited appeals of health care services and other appeals for health care services that meet the minimum requirements outlined herein. If the case involves an adverse determination the HMO must provide the procedures for requesting an external independent review.	
Health Care Services Appeals, Complaints, and External Independent Reviews	215 ILCS 5/155.36 50 IL Adm. Code 134/45	Managed Care Act appeals, complaints and external review provisions have now been added to insurer requirements as well.	
Notice of Nonrenewal or Termination	215 ILCS 134/20	A health care plan is required to provide 60 days notice of nonrenewal or termination of a health care provider to both the provider and to his/her enrollees.	
POINT OF SERVICE (POS) PLAN REQUIREMENTS	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	
Filing of POS Product	215 ILCS 125/4.5-1 50 IL Adm. Code 5421.113	The filing must include an HMO portion (base) and an indemnity portion. The HMO filing must be filed with the HMO unit and the indemnity portion must be filed with the LAH unit. Illinois does not permit a POS plan with a preferred provider organization (PPO) base and an HMO “tail” (out-of-network piece).	
GENERAL INFORMATION	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	
Civil Unions	Company Bulletin 2011-06	The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75/, allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.	

Rate Filing Required	50 IL Adm. Code 5421.60 215 ILCS 125/4-12 Company Bulletin 2010-08	An HMO must file its rates with the Department's actuarial unit. The Federal Patient Protection and Affordable Care Act (PPACA) has established premium reporting and review processes for all health insurance issuers. The Rate Filing Actuarial Memorandum and Rate Data Collection Form are available on the Department's web site under Company Bulletin 2010-08.	
Standardized Individual and Small Employer Application Form	215 ILCS 5/359b 50 IL Adm. Code 2030 Company Bulletin 2010-10	All health insurance carriers offering health benefit plans in either the individual or small group market must use the standard health application beginning on January 1, 2011.	
Retrospective Rate Filings	215 ILCS 125/5-3 (f)	An HMO may effect refunds or charge additional premium under the circumstances described.	
Medically Necessary Dispute Resolution	215 ILCS 125/4-10	Each HMO must establish a dispute resolution process in which a physician, holding the same class of license as the PCP and not affiliated with the HMO, is jointly selected by the patient and the HMO in the event of a dispute regarding medical necessity of a covered service proposed by the patient's PCP. In the event the reviewing physician determines the covered service is medically necessary the HMO will be required to provide the service.	
Provision of Information	50 IL Adm. Code 5421.110 q) 50 IL Adm. Code 5420.40	An HMO must provide to each enrollee information regarding its functions, organization, and related institutions and describe the appropriate use of its services. This material must also include a description of the grievance procedure, directions on filing a grievance and "Notice of Availability of the Division". HMOs must provide description of coverage worksheets as detailed in 50 IL Adm. Code 5420.40.	
ID Card Required	50 IL Adm. Code 5421.110 r) 215 ILCS 139/15	HMOs must provide ID cards to their enrollees. Mandatory data elements for the card or other technology include: • Processor control number if required for claims adjudication; • Group number; • Card issuer identifier; • Cardholder ID number; and • Cardholder name. The back of the card or other technology is to include the claims submission names and addresses and the help desk telephone numbers and names. Cards must be issued upon enrollment and reissued upon any change in the enrollee's coverage that affects any of the required elements.	
Use of SSN on ID Cards	815 ILCS 505 2QQ 215 ILCS 138/15	The focus of HB 4712 is on any card required for an individual to access products or services, while SB 2545 is more limited in that it just focuses on insurance cards. HB 4712 prevents a person from: • Publicly posting or displaying an individual's SSN;	

		• Printing an individual's SSN on any card required for the individual to access products or services, however, an entity providing an insurance card must print on the card a unique identification number as required by 215 ILCS 138/15. • Being required to transmit an SSN over the Internet to access a web site unless the connection is secure or the SSN is encrypted; • Requiring the individual to use his/her SSN to access a web site unless a PIN number or other authentication device is also used; and, • Printing an individual's SSN on any materials mailed to an individual unless required by state or federal law. Insurers must comply with both provisions.	
Discrimination	50 IL Adm Code 2603	Guidelines for Unfair Discrimination based on sex, sexual preference or marital status. Forbids excluding coverage for dependent child maternity.	
Basic Outpatient Preventive and Primary Health Care Services for Children	215 ILCS 125/4-17 50 IL Adm. Code 5421.131	An HMO may choose to provide or arrange to pay for or reimburse the cost of basic outpatient preventive and primary health care services for children who are without health care coverage.	
Dental Coverage Reimbursement Rates	215 ILCS 5/355.2 215 ILCS 125/5-3(a)	A group contract or evidence of coverage that also includes dental and bases reimbursement on usual and customary fees must disclose specific information.	
HIV/AIDS Questions on Application	215 ILCS 5/143(1)	Questions designed to elicit information regarding AIDS, ARC and HIV must be specifically related to the testing, diagnosis or treatment done by a physician or an appropriately licensed clinical professional acting within the scope of his/her license.	
Prohibition against Substitution of Hospitalist	215 ILCS 5/134/30(c)	No health care plan, or one of its subcontractors, may require an enrollee who is hospital confined to substitute his/her primary care physician for a hospitalist who is under the control of that entity.	
Organ Transplant Medication Notification Act	215 ILCS 175	Provides guidelines for health insurance policies and health care service plans that cover immunosuppressant drugs.	
Use of Information Derived from Genetic Testing	215 ILCS 5/356v 215 ILCS 97/20(A)(1) 215 ILCS 125/5-3(a)	Insurers must comply with the Genetic Information Privacy Act as well as the provisions found in 215 ILCS 97/20(A)(1).	
Benefit	**Benchmark Requirement**	**Conditions for Coverage or Limitations**	
1. Ambulatory Patient Services			
Primary Care to treat illness/injury	Yes		
Specialist visits	Yes		
Pediatrician office visit	Yes		

Urgent care facility	Yes		
Surgery facility – outpatient procedure at an ambulatory surgical center	Yes		
Surgery – Assistant Surgeon	Yes		
Additional Surgical Opinion	Yes	Following a recommendation for elective surgery. Covered at 100% of claim charge for one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in your opinion, is not resolved by the first consultation	
Blood and blood components	Yes	Includes, but is not limited to, all clotting factors necessary for the treatment of blood disorders, such as hemophilia	.
Dental Ancillary Services	Yes	Mandated - Only covered in the event of an accident.	
Chemotherapy	Yes	Both outpatient and in-patient settings, services would be eligible, based on medical necessity.	.
Radiation Therapy	Yes	Both outpatient and in-patient settings, services would be eligible, based on medical necessity.	
Biological Drugs	Yes		
Oxygen and its administration	Yes		
Outpatient end stage renal disease treatment	Yes	Both outpatient and in-patient settings, services would be eligible, based on medical necessity.	
Infertility treatment services	Yes 215 ILCS 5/356m 50 IL Adm Code 2015	Mandated - The treatment of infertility is only required for employer groups with more than 25 employees.	
Sterilization	Yes		
Home health care	Yes	You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).	

Outpatient Contraceptive Services	Yes	Mandated. Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.	
Dental care required for the direct treatment of a medical condition	No	May be covered if specifically and directly related to the medical condition i.e. dental work needed in order to treat cancer itself or dental care required to be performed in order to treat another underlying medical condition. For example the treatment of malnutrition or digestive disorders in the young and elderly due to underlying dental and oral problems.	.
Dental care due to accident or injury – Adult	Yes	Coverage only for sound natural teeth	
Routine Foot care	No	Mandated – Except for persons with diabetes.	
Routine Care During Cancer Clinical Trials	Yes	Mandated	
2. Emergency Services			
Definition of Emergency Medical Condition	50 IL Adm. Code 5421.110 g) 50 IL Adm. Code 5421.130 d) 215 ILCS 134/10 215 ILCS 134/65	The group contract and evidence of coverage must include a specific description of benefits available for emergencies 24 hours a day, 7 days a week. No HMO may limit emergency services within the service area to contracted providers. A health care plan must use this definition that includes “prudent lay person” language	
Emergency services – facility	Yes		
Emergency Coverage Under the Influence of Alcohol or Narcotics	215 ILCS 5/367k	No policy may exclude coverage for any emergency or other medical, hospital or surgical expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered.	
Emergency services – physician	Yes		
Criminal Sexual Assault Emergency medical care resulting from a criminal sexual assault or abuse	215 ILCS 125/4-4 yes	Coverage for criminal sexual assault must be at the same benefit levels as any other emergency or accident care situation. Covered at 100% with no cost-sharing	

Ambulance service – ground and air	Yes 215 ILCS 125/4-15	The evidence of coverage must include coverage for emergency transportation by ground or air ambulance. Not provided for long distance trips because it is more convenient than other transportation	
3. Hospitalization			
Inpatient medical and surgical care	Yes		
Surgery – assistant surgeon	Yes		
Human Organ Transplants	215 ILCS 125/4-5	No accident and health insurer may deny reimbursement for an organ transplant as experimental or investigational unless supported by appropriate, required documentation. Benefits for transportation and lodging are limited to a maximum of $10,000 per transplant. Max for lodging per person, per day, is $50. Benefits are available to both the recipient and donor of a covered transplant as follows: • If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own program. • If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits. • If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient. • Benefits will be provided for: • Inpatient and Outpatient Covered Services related to the transplant Surgery. • the evaluation, preparation and delivery of the donor organ. • the removal of the organ from the donor. • the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at in-network approved Human Organ Transplant Coverage Program.	
Bariatric surgery	Yes	If medically necessary	
Anesthesia	Yes		
Oral surgery/TMJ services and devices	Yes 215 ILCS 5/356q Insurers providing hospital, medical or surgical care must offer coverage for TMJ and	Limited to: • surgical removal of complete bony impacted teeth; • excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; • surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; • excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone;	

	craniomandibular disorder.	external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.	
Breast reconstruction after mastectomy	Yes 215 ILCS 125/4-6.1(b) 50 IL Adm. Code 5421.132	Mandated Coverage requires: reconstruction of breast upon which mastectomy performed; surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment for physical complications at all stages of mastectomy, including lymphdemas. Written notice of the availability of this coverage must be delivered to the enrollee upon enrollment and annually thereafter.	
Post Mastectomy Care	215 ILCS 5/356t 215 ILCS 125/4-6.5	Coverage must provide inpatient treatment following mastectomy for length of time to be determined by attending physician; must also provide for availability of post-discharge physician office visit or in-home nurse visit within 48 hours of discharge.	
Breast Implant Removal	215 ILCS 125/4-6.2	No HMO contract may deny medically necessary breast implant removal for a sickness or injury. This provision does not apply to the removal of breast implants that were done solely for cosmetic purposes.	
Fibrocystic Breast Condition	215 ILCS 125/4-16	No contract or evidence of coverage may deny or exclude coverage for fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the enrollee's medical history is able to confirm a chronic, relapsing, symptomatic breast condition.	
Breast Cancer Pain Medication and Therapy	215 ILCS 5/356g.5-1 215 ILCS 125/5-3(a)	Coverage must include all medically necessary pain medication and pain therapy related to the treatment of breast cancer under the same terms and condition applicable to treatment of other conditions. The term "pain therapy" is defined.	
Reconstructive surgery (other than related to mastectomy)	Yes	Limited to correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases	
Blood transfusions	Yes		
Hospice	Yes.	You must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Coverage includes: • Coordinated Home Care; • Medical supplies and dressings; • Medication; • Nursing Services − Skilled and non-Skilled; • Occupational Therapy; • Pain management services; • Physical Therapy; • Physician visits; • Social and spiritual services; • Respite Care Service.	

Respite care	Yes	Only available with hospice	
4. Maternity and Newborn Care			
Pre and post natal Care Services	Yes		
Prenatal HIV testing	215 ILCS 5/356z.1 215 ILCS 125/4-6.5	Must be provided if coverage includes maternity benefit.	
Delivery and inpatient maternity services	Yes		
Post-Parturition Care	215 ILCS 5/356(s) 215 ILCS 125/4-6.4 50 IL Adm. Code 5421.130 e) 50 IL Adm. Code 2603.30 a) 11)	Coverage must include prenatal and post-natal care and complications of pregnancy for mother as well as care of newborn. Coverage must provide minimum of 48 hours inpatient care for normal delivery and 96 hours for caesarian section. Shorter lengths of stays are permitted based on decision of the PCP.	
Newborn child coverage	Yes		
5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment			
Alcoholism and Drug Abuse	50 IL Adm. Code 5421.130 i)	Coverage must include diagnosis, detoxification and treatment of medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis. Rehabilitation services must be included.	
Mental, Emotional or Nervous Disorders/Serious Mental Illness Mental Health Parity	Bulletin 99-6 215 ILCS 5/370c, c.1	The coverage must meet the minimum requirements of the Mental Health Parity Act. Please see Division Bulletin 99-6 The benefit for serious mental illness, based on medical necessity, in addition to requiring 45 days of inpatient treatment also requires 60 outpatient visits and an additional 20 outpatient visits for speech therapy for the treatment of pervasive developmental disorders. Benefits for serious mental illness are not applicable for small group.	
Mental/Behavioral Health/Substance Use Disorder - Inpatient Hospital	Yes		.
Mental/Behavioral Health/ Substance Use Disorder – Outpatient		Includes, but is not limited to, psychological testing, neuropsychological testing, electroconvulsive therapy, intensive outpatient programs, partial hospitalization treatment programs, if it is an in-network approved program.	

Emergency MH/SUD Admission	Yes	Requires Mental Health Unit Review	
Partial Hospitalization	Yes	May require to be rendered in an in-network approved program	
Intensive Outpatient Treatment	Yes	Requires Mental Health Unit Review	
Residential Treatment Facility	Yes	Only for SUD disorders. Please confirm that residential treatment centers for SUD disorders is a covered expense, as mandated by the Illinois State Mandate	.
Detoxification	Yes	Covered	
Applied Behavior Analysis Based Therapies	Yes	Mandated - only for Autism Spectrum Disorder	
Electroconvulsive Therapy	yes		
Other MH/SUD Exclusions (this is not an exhaustive list)		Exclusions include but may not be limited to: • Residential treatment centers, except for SUD • Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders. • Investigational treatments (see Other Exclusions below) • Services provided that are not for the treatment of a Mental Illness, defined as illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. • Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner. • Substance Abuse Rehabilitation Treatment does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats. • Substance Abuse Treatment Facility does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.	
6. Prescription Drugs			
Retail	Yes		
Mail Order	Yes		

Generic Brand	Yes		
Specialty	Yes		
Self-Injectibles medications	Yes		
Insulin/needles for diabetes	Yes		
Fertility Drugs	Yes	Mandated	
Biological Drugs	Yes		
Growth Hormone Therapy	Yes		
Organ Transplant Medication Notification Act	215 ILCS 175	Provides guidelines for health insurance policies and health care service plans that cover immunosuppressant drugs.	
Cancer Drug Parity	215 ILCS 5/356z.20	The financial requirements applicable to orally-administered cancer medications may be no different than those same requirements applied to intravenously administered or injected cancer medications.	
Prescription Drugs; Cancer Treatment	215 ILCS 5/356z.7	Coverage for prescribed drugs for certain types of cancer shall not exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration if proper documentation, as outlined, is provided.	
Prescription Inhalants	215 ILCS 5/356z.5 215 ILCS 125/5-3(a)	If the group contract provides RX coverage it may not deny or limit coverage for prescription inhalants when diagnosis is asthma or other life-threatening bronchial ailments; additional guidelines provided.	
Coverage for contraceptives	215 ILCS 5/356z.4 215 ILCS 125/5-3(a)	If the group contract provides coverage for OP services and RX or devices it must provide enrollee and dependent coverage for all OP and contraceptive drugs and devices approved by the FDA; may not impose greater copays, ded or waiting periods.	
7. Rehabilitative and Habilitative Services and Devices			
Physical Therapy	Yes	A written plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by Multiple Sclerosis	
Preventive Physical Therapy for Multiple Sclerosis Patients	215 ILCS 5/356z.8 215 ILCS 125/5-3(a)	Mandated Coverage must provide for medically necessary preventative physical therapy for insureds diagnosed with this disease. A definition of “preventative physical therapy” is included. Coverage limitations, deductibles, coinsurance features, etc. must be provided the same as any other illness.	

Occupational Therapy	Yes	A written plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis	
Speech Therapy	Yes	Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.	
Pulmonary Rehabilitation Therapy	Yes	Is covered based on medical necessity	
Cardiac Outpatient Rehab Services		Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period. Benefits will be provided only in an in-network approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.	
Inpatient Rehabilitation	Yes		
Autism Spectrum Disorder Coverage	Yes 215 ILCS 5/356z.14 215 ILCS 125/5-3	Mandated Coverage must be provided for individuals under age 21 for the diagnosis and treatment of autism spectrum disorders to the extent that such care is not already covered by the policy.	
Habilitative Services	215 ILCS 5/356z.15 215 ILCS 125/5-3	Mandated A group or individual policy of accident and health or a managed care plan must provide coverage for habilitative services for children less than 19 years of age with congenital, genetic, or early acquired disorders as described	
Chiropractic & Osteopathic Manipulation	Yes	$1,000 per benefit period	
Massage Therapy	Yes	Massage therapy is eligible benefit but a massage therapist most likely will not be acceptable as a provider	
Skilled Nursing facility Services	Yes		
Durable Medical Equipment	Yes		
Prosthetics	Yes. 215 ILCS 5/356z.18 215 ILCS 125/5-3(a)	A group or individual major medical policy of accident or health insurance or a managed care plan must provide coverage for prosthetic and orthotic devices subject to other general exclusions, limitations and financial requirements of the policy.	
Orthotics			
Hearing Aids	No	Hearing aids are not covered. Not for adults or for children	
Cochlear Implants	Yes.	Covers osseointegrated auditory implants	

8. Laboratory Services			
Lab Tests, X-ray services and Pathology – Inpatient	Yes		
Lab Tests, X-ray services and Pathology – Outpatient	Yes		
Imaging/Diagnostics (eg. MRI, CT scan, PET scan) - Inpatient	Yes		
Imaging/Diagnostics (eg. MRI, CT scan, PET scan) - Outpatient	Yes		
9. Preventive and Wellness Services and Chronic Disease Management			
Preventive Services Covered Under the Affordable Care Act	Public Law 111-148-Patient Protection and Affordable Care Act	The Department requires the complete list of preventive covered services to appear in the certificate of insurance. The Department will not accept referring an insured to a web site or a 1-800 phone number. The list also includes covered preventive services for women as well.	
Wellness Coverage	215 ILCS 5/356z.17 215 ILCS 125/5-3(a)	Individual and group accident and health insurers and HMOs may offer reasonably designed programs for wellness coverage.	
Cardiovascular Disease	215 ILCS 5/356z.19	Insurers and managed care plans must develop and implement procedures to communicate on an annual basis with adult enrollees regarding the importance and value of early detection and proactive management of cardiovascular disease.	
Preventive Health Care for Women	Company Bulletin 2012-05	The federal Affordable Care Act (ACA) requires health care plans to include women's preventive health care such as mammograms, screening for cervical cancer, prenatal care and other services to be covered without cost sharing (when delivered by a network provider) by non-grandfathered group plans beginning on or after September 23, 2010 and by individual insurance plans beginning on or after the same date. Additionally, health care plans must now comply with the guidelines released by the Health Resources and Services Administration (HRSA) on August 1, 2011. Non-grandfathered plans and issuers are required to provide coverage without cost sharing consistent with these guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012. The HRSA web site is located at: http://www.hrsa.gov/womensguidelines/.	

Preventive Services	Yes		
Immunizations	Yes		
Bone Density Test /Osteoporosis	Yes 215 ILCS 5/356z.6 215 ILCS 125/5-3(a)	Coverage must include medically necessary bone mass measurement and diagnosis and treatment of osteoporosis the same as any other illness.	
Colorectal Cancer Screening	Yes 215 ILCS 5/356x 215 ILCS 125/5-3(a)	Must cover all colorectal cancer exams and lab tests for colorectal cancer as prescribed by PCP according to stated guidelines; may not impose greater co-pays, deductibles or waiting periods.	
Screening Mammography	Yes 215 ILCS 125/4-6.1(a)	Coverage of screening by low-dose mammography for all women over 35; Coverage requires baseline mammogram for women 35-39 and annual mammogram for women 40 years of age and older. For women under 40 with a family history of breast cancer or other risk factors mammograms must be provided at an age and intervals considered medically necessary. Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described. Coverage must be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit. When coverage is available through contracted providers and such a provider is not utilized, plan provisions specific to the use of those non-contracted providers must be applied without distinction to the coverage required and shall be at least as favorable as for other radiological examinations covered by the policy or contract.	
Clinical Breast Exam	215 ILCS 5/356g.5 215 ILCS 125/4-6.5	Clinical breast examinations must be covered: (1) at a minimum every three years for women over 20 years of age but less than 40; and, (2) annually for women 40 years of age and older.	
Qualified Clinical Cancer Trials	215 ILCS 5/364.01 (c)-(j) 215 ILCS125/5-3(a)	No group policy of accident and health insurance shall exclude coverage for any routine patient care for an insured participating in a qualified clinical cancer trial if the policy covers that same care for insureds not so enrolled. No insurer may cancel or non-renew any individual's coverage due to participation in a qualified clinical cancer trial.	
Shingles Vaccine	215 ILCS 5/356z.13 215 ILCS 125/5-3(a)	Coverage must include a vaccine for shingles that is approved by the federal Food and Drug Administration if it is ordered by a physician for an insured/enrollee who is 60 years of age or older.	
Preventive Foot Care	For persons with diabetes		
Allergy testing and treatment	Yes		
Nutrition	Yes	Diabetes education and habilitative services	
Diabetes Care Management	Yes		

Diabetes – Testing Medically necessary equipment and supplies	Yes 215 ILCS 5/356w 215 ILCS 125/5-3(a) 50 IL Adm. Code 2019	Coverage must be provided for outpatient self-management training and education, equipment and supplies. Guidelines are provided. Insulin pumps are a covered benefit.	
Smoking Cessation Program	Yes 215 ILCS 5/356z.21	Insurers providing hospital or medical treatment or services must offer coverage of up to $500 annually for a tobacco use cessation program for persons enrolled in the plan who are 18 years of age or older.	
Screening Pap Tests	Yes 215 ILCS 5/356u 215 ILCS 125/4-6.5	Coverage must include annual cervical smear or Pap smear test for female insureds, including surveillance tests for ovarian cancer for female insureds who are at risk for ovarian cancer	
Coverage for Human Papillomavirus Vaccine	215 ILCS 5/356z.9 215 ILCS 125/5-3(a)	Coverage must include benefit for FDA approved human papillomarivus vaccine (HPV).	
Prostate Cancer Screening	Yes 215 ILCS 5/356u 215 ILCS 125/4-6.5	Annual digital rectal examination and prostate-specific antigen test for males upon recommendation of physician. Must include asymptomatic men age 50 and over; African-American men age 40 and over; and men age 40 and over with family history of prostate cancer.	
Women's Principal Health Care Provider	215 ILCS 125/5-3.1 215 ILCS 5/356r	An HMO that requires enrollees to select a PCP must allow female enrollees the right to select a participating woman's principal health care provider. Notification is required.	
10. Pediatric Services, including Oral and Vision Care	**Section 1302 of the Affordable Care Act (ACA)**	**Pediatric dental coverage may be submitted as variable language. To the extent, there is a standalone dental plan offered on the Exchange this coverage may be removed. Pediatric vision care must be fully outlined in the policy benefits.**	
Preventive Care – Physician Services	Yes		
Immunizations	Yes		
Treatment of Illness or Injury - Child	Yes		
Amino acid-based elemental formulas	Yes, 215 ILCS 5/356z.10 215 ILCS 125/5-3(a)	Coverage must include reimbursement for amino acid-based elemental formulas, regardless of delivery method, for diagnosis and treatment of conditions described herein. Vaccine	
Adjunctive Services in Dental Care	215 ILCS 5/356z.2 215 ILCS 125/5-3(a)	This coverage is limited to children age 6 or under; to individuals with medical conditions that require hospitalization and general anesthesia for dental care; and for disabled individuals.	
Dental Accidents or Injury	Yes	Limited to treatment of sound natural teeth	
Dental care required for the direct treatment of a medical condition	No	May be covered if specifically and directly related to the medical condition i.e. dental work needed in order to treat cancer itself or dental care required to be performed in order to treat another underlying medical condition. For example the treatment of malnutrition or digestive disorders in the due to underlying dental and oral problems.	

Hearing Aids – child	Yes	Limited to $600 every 3 years	
Cochlear Implants – Child	Covers osseointegrated auditory implants		
Routine Hearing Exams – child	Yes	Limited to $150 per year However, covered if related to medical diagnosis; covered for newborns with maternity care; paid same as any other services	
Benefit	Benchmark Requirement	Conditions for Coverage or Limitations	
DEPARTMENT POSITIONS	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
Hospital Definition	215 ILCS 5/143(1)	The definition of hospital must allow for those hospitals providing surgery, etc., on a formal arrangement basis with another institution.	
Precertification penalties	215 ILCS 5/143(1)	The Division will permit a failure to precertify a hospital admission penalty of the lesser of up to $1,000 or 50% of the billed charge. The penalty may be no more frequent than a per confinement basis.	